U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 30 April 2007

Case No. 2006-BLA-5645

In the Matter of
C.E.S. [1],
Claimant,

v.

SOUTHERN OHIO COAL CO.,
Employer,
and
OHIO BUREAU OF WORKERS
COMPENSATION,
Carrier,
and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Terrance W. Larrimer, Esq.
On behalf of Claimant

Gregory K. Johnson, Esq.
On behalf of Employer

Patrick L. Depace, Esq.
On behalf of Director

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF MODIFICATION

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis*

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On April 28, 2006, the Director, Office of Workers' Compensation Programs referred this case to the Office of Administrative Law Judges for a formal hearing. (DX 22).[3] The undersigned Administrative Law Judge conducted a formal hearing on this matter on November 16, 2006 in Athens, Ohio. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

---

added). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[4] At the hearing, the parties stipulated to at lease 25 years of coal mine employment. (Tr. 12)

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner was totally disabled;

4. Whether the Miner's disability or death was due to pneumoconiosis; and

5. Whether the evidence establishes a change in condition and/or that a mistake was made in the determination of any fact in the prior denial under § 725.310.

(DX 22).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

C.E.S. ("Claimant") was born on March 2, 1940 and was 66 years old at the time of hearing. (DX 4). He completed the eighth grade. (DX 4; Tr. 17). On November 25, 1959, he married D.A.S., and they remain married and live together. (DX 4, 7). He has no dependent children. (DX 4). I find that Claimant has one dependent for purposes of augmentation.

On his application for benefits, Claimant stated that he engaged in coal mine employment for 26 years. (DX 4). Claimant's coal mine employment was as a beltman and performing assembly and repair of the belt lines. (DX 5; Tr. 22). Claimant last worked in or around the coal mines in September 2001. (DX 4; Tr. 15).

Procedural History

Claimant filed his initial claim for benefits on December 15, 1998. (DX 1). On April 26, 1999, the District Director issued an initial denial. On June 16, 2002, Claimant filed a second claim for benefits. (DX 2). On March 18, 2003, the Director issued a proposed decision and order - denial of benefits. Claimant did not appeal either of these decisions.

The instant claim was filed on April 27, 2004. (DX 4). On February 1, 2005, the Director issued a decision and order – denial of benefits. (DX 15). Claimant did not appeal, but on January 26, 2006, he filed a timely request for modification. (DX 16). On March 22, 2006, the District Director answered with a proposed decision and order denying Claimant's request

for modification. (DX 19). On March 23, 2006, Claimant filed a request for a formal hearing. (DX 20). This matter was transferred to the Office of the Administrative Law Judges on April 28, 2006. (DX 22).

Length of Coal Mine Employment

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations. Claimant stated that he engaged in coal mine employment for 26 years. (DX 4). The parties, however, have stipulated that Claimant engaged in at least 25 years of coal mine employment. (Tr. 12). Since the parties' stipulation is supported by the record, (DX 1-2, 5-6), I find that Claimant engaged in at least 25 years of coal mine employment.

Claimant's last employment was in the State of Ohio, (DX 1-2); therefore, the law of the Sixth Circuit is controlling.[5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Southern Ohio Coal Co. as the putative responsible operator due to the fact that it was the last mine operator for whom the miner worked a year or more. (DX 15). Southern Ohio Coal Co. does not contest this issue. After review of the record, I find that Southern Ohio Coal Co. is properly designated as the responsible operator in this case.

NEWLY SUBMITTED MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. Claimant designated Dr. Mavi's August 2002 complete medical report. This report was considered in conjunction with Claimant's second claim for benefits. He also designated Dr. Linder's PFT study that was considered in conjunction with the first claim for benefits. As this is a subsequent claim, these records will only be considered in the event Claimant is able to demonstrate a change in conditions based on the newly submitted evidence. Next, Claimant designated Dr. Mavi's November 16, 2004 report found at DX 18. I find that this report is actually one of many medical treatment records spanning 2002[6] through 2006. Director's exhibit number 18 also includes a February 7, 2006 letter from Dr. Mavi, which constitutes a medical report. Claimant also designated Dr. Siciliano's July 28, 2003 CT scan and Dr. Englund's February 8, 2002 catheterization study. This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit Dr. Mavi's letter and the newly submitted treatment notes.

Employer did not complete a Black Lung Benefits Act Evidence Summary Form. The parties were granted 30 days post-hearing to submit additional evidence. On December 15, 2006, Employer submitted a medical report by Dr. Grodner which is identified as EX 1. This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit Dr. Grodner's report into the record for consideration.

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height[7]**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 18 9/4/03	Not listed/ Not listed/ No	65 '----	2.03	2.89		70	No

Narrative Reports

Dr. Santpal Mavi submitted a letter Dated February 7, 2006. (DX 18). Dr. Mavi stated that Claimant has a 26-year coal mine employment history, he has COPD, and he is a reformed smoker. Dr. Mavi opined that pneumoconiosis is strongly considered because of the extended period of time Claimant worked in the mines, and because exposure over that much time "can certainly cause pneumoconiosis".

[6] These records include three entries from August 22, 2002, which were submitted as part of Claimant's second claim for benefits. These reports will only be considered in this adjudication if Claimant is able to prove a change of conditions based on the newly submitted evidence.

[7] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Miner's height to be 69 inches.

Dr. Herbert Grodner submitted a supplemental medical report on December 4, 2006, in which he considered Claimant's newly submitted evidence. (EX 1). He opined that Claimant does not have pneumoconiosis or any chronic respiratory or pulmonary disease related to or arising out of his coal mine employment. He explained that none of the x-ray interpretations mention pneumoconiosis, and while the CT scan noted minimal fibrotic changes, it failed to mention the presence of nodular opacities or irregular opacities and did not define the type of fibrotic changes. Dr. Grodner stated that Claimant's COPD is obstructive and is related to cigarette smoking. Dr. Grodner further explained that Claimant's mild to moderate COPD and emphysema would make it difficult for him to perform the exertional requirement of his previous coal mine employment. However, he also emphasized that Claimant's "difficulty" performing coal mine work was due to his pulmonary condition in conjunction with his heart disease, hypertension, and hyperlipidemia.

Hospitalization Records and Treatment Notes

The record includes the following hospitalization records and treatment notes from the Holzer Clinic. The pertinent reports are summarized here in chronological order.

February 8, 2002 – Catheterization study by Dr. Englund: ASHD. Angina Pectoris is stable. (CX 3).

December 26, 2002 – X-ray by Dr. Casanova: There is no acute infiltration. Calcified granuloma in the left upper lobe unchanged since 2/14/00. Here is moderate hyperinflation of the lungs compatible with COPD. (DX 18).[8]

July 30, 2003 – CT scan report by Dr. Sicioiano: Mild chronic changes involving the chest without evidence of significant fibrosis or non-calcified pulmonary parenchymal nodule. (CX 2).

August 29, 2003 – Examination report by Dr. Mavi: Patient presented with COPD and shortness of breath. He has smoked for 39 years and worked in the coal mines for 26 years. His June 2003 chest x-ray is unremarkable. The 2002 PFT showed moderate to severe air flow obstruction. He has a previous history of COPD. Lungs show poor air movement and prolongation of expiratory phase and a few expiratory wheezes. He had a cardiac catheterization done in 2002 which reported minimal blockages of 20-25 % but no major coronary blockage reported. Assessment: COPD and pneumoconiosis. (DX 18).

October 31, 2003 – Examination report by Dr. Mavi: Patient has a previous history of COPD, pneumoconiosis, and allergic rhinitis. A PFT (charted above) showed moderate airflow

[8] Included in the treatment notes are various x-ray reports. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

obstruction with no bronchodilator response. He does have some brownish colored discharge from his nose. Lungs show poor air movement but fairly clear with no wheezes. Assessment: Acute bronchitis/sinusitis, COPD, and pneumoconiosis. (DX 18).

January 20, 2004 – Examination report by Dr. Mavi: Patient has a previous history of COPD, pneumoconiosis, and allergic rhinitis. He is a reformed smoker. Lungs show poor air movement but fairly clear with no crackles or wheezes. Assessment: COPD, pneumoconiosis, and allergic rhinitis. (DX 18).

.

April 19, 2004 – Examination report by Dr. Mavi: Patient has a previous history of COPD, pneumoconiosis, and allergic rhinitis. He complains of having bronchitis off and on. He is a reformed smoker. Lungs show bilateral scattered wheezes. Assessment: COPD, pneumoconiosis, acute bronchitis, and allergic rhinitis. (DX 18).

July 14, 2004 – Examination report by Dr. Mavi: Patient has a previous history of COPD and pneumoconiosis. He is a reformed smoker. Lungs were fairly clear with no active crackles or wheezes and he has prolongation of expiratory wheeze. Assessment: COPD, pneumoconiosis, and allergic rhinitis. (DX 18).

July 19, 2004 – X-ray report by Dr. Brittingham: No acute active cardiopulmonary disease or pathology. No mediastinal mass is present. Impression: Radiographically stable non-acute chest x-ray. (DX 18).

November 16, 2004 - Examination report by Dr. Mavi: Patient presents with mild shortness of breath and some chest discomfort. He had a cardiac catheterization in 2002 which was unremarkable. He has a history of COPD allergic rhinitis, and pneumoconiosis and is a reformed smoker. Lungs are fairly clear but occasional wheeze in the base is noted, particularly on forced expiration. Assessment: chest cold like symptoms, coughing, wheezing, and discolored sputum. He has a history of COPD and pneumoconiosis and is a reformed smoker. Lung examination shows bilateral scattered wheezes and rhonchi. Assessment: COPD, pneumoconiosis, and allergic rhinitis. (DX 18).

February 16, 2005 – Examination report by Dr. Mavi: Patient presents with chest cold like symptoms, coughing, wheezing, and discolored sputum. He has a history of COPD and pneumoconiosis and is a reformed smoker. Lung examination shows bilateral scattered wheezes and rhonchi. Assessment: Acute bronchitis causing COPD exacerbation. Pneumoconiosis and allergic rhinitis. (DX 18).

May 19, 2005 – Examination report by Dr. Mavi: Patient has a previous history of COPD and pneumoconiosis. He has had some dyspnea and chronic cough with clearish to whitish sputum production. The July 19, 2004 x-ray showed some chronic changes but was otherwise stable. He is a reformed smoker. Lungs were bilaterally clear with no active crackles or any wheezes. Assessment: COPD is stable. (DX 18).

May 20, 2005 – X-ray by Dr. Mavi: Compared to the July 19, 2004 examination, there is moderate hyperinflation of the lungs compatible with COPD. (DX 18).

September 16, 2005 – Examination report by Dr. Mavi: Patient has a previous history of COPD and chronic sinus problems. His May 2005 x-ray showed COPD but was otherwise unremarkable. He is a reformed smoker. Physical examination showed bilateral poor air movement but fairly clear. Assessment: Stable COPD for his sinus problems. (DX 18).

December 20, 2005 – Examination report by Dr. Mavi: Patient complains of brownish to yellowish colored sputum, wheezing, and shortness of breath. The May 2005 x-ray revealed COPD without any acute lung mass or infiltrate. He has a previous medical history of COPD, pneumoconiosis, chronic sinus problems, hypertension, and hyperlipidemia. He is a reformed smoker and has a prior history of coal mine employment. Physical examination showed poor air movement bilaterally with occasional wheeze in the basal lung zones. Assessment: Acute bronchitis, COPD, and pneumoconiosis. (DX 18).

February 3, 2006 – Examination report by Dr. Mavi: Patient presents with head congestion and states that he is coughing up brown sputum. He also states that he is experiencing abdominal pain, a decrease in appetite and shortness of breath with exertion. He has a previous medical history of COPD and pneumoconiosis, he is a reformed smoker and has a prior history of coal mine employment. Assessment: acute bronchitis, COPD, pneumoconiosis, and reflux. (DX 18).

PREVIOUSLY SUBMITTED MEDICAL EVIDENCE[9]

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 9	8/30/04	09/7/04	Fax, B-reader[10]	Negative
DX 9	8/30/04	10/6/04	Gaziano, B-reader	Quality only

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 9 8/30/04	Not listed/ Not listed/ Yes	64 69”	1.95	2.82		69	No

* indicates post-bronchodilator values

[9] This is a summary of all evidence submitted in conjunction with Claimant’s third claim for benefits up to his January 2006 request for modification.

[10] A “B” reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 9	8/30/04	39.5 43.6*	76.4 76.2*	No No*

* indicates post-exercise values

Narrative Reports

Dr. Grodner examined Claimant on August 30, 2004 and submitted a report. (DX 9). Dr. Grodner considered the following: symptomatology (sputum, wheezing, dyspnea, cough, chest pain, ankle edema, and paroxysmal nocturnal dyspnea), employment history (25 years coal mine employment, working as a laborer, miner helper, rock duster, and a trackman), individual history (frequent colds, attacks of wheezing, chronic bronchitis, allergies, COPD, and high blood pressure), family history (high blood pressure, heart disease, cancer, and allergies), smoking history (smoked 4 to 5 pipes per day beginning in approximately 1965, and stopping in 1998), physical examination (normal except for inspirational crackle), chest x-ray (unremarkable), PFT (mild obstructive airways disease), ABG (mild hypoxemia, no response to exercise), and an EKG (possible remote interior damage). Dr. Grodner diagnosed COPD based on the PFT, ABG, and Claimant's reported symptomatology and stated that this condition was possibly due to smoking. He opined that Claimant had a mild pulmonary impairment and that he would be able to perform his previous coal mine employment.

Smoking History

Claimant testified that he was a light smoker. (Tr. 25). He also stated that he actually smoked closer to ½ packs of cigarettes per day for 30 years until he quit in 1984. (Tr. 25-26, 28-29). However, he admitted to smoking an occasional pipe since 1984. (Tr. 27). Dr. Grodner reported that Claimant smoked 4 to 5 pipes per day beginning in approximately 1965, and ending in stopping in 1998. (DX 9). Based on these reported smoking histories, I find that Claimant smoked ½ packs per day for 30 years, or 15 pack-years. I also find that while he quit smoking cigarettes in 1984, he continued to smoke four to five pipes of tobacco per day until at least 1998.

DISCUSSION AND APPLICABLE LAW

Claimant filed his claim on April 27, 2004. Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). To establish entitlement to benefits in the living miner's claim under Part 718, Claimant must establish, by a preponderance of the evidence, that her husband:

1. Was a miner as defined in this section; and

2. Met the requirements for entitlement to benefits by establishing that he:

   (i) Had pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Was totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributed to the total disability (see § 718.204(c)); and

3. Had filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by § 725.310, provides that upon his or her own initiative, or upon the request of any party on the ground of a change in conditions or because of a mistake in a determination of fact, the deputy commissioner may, at any time prior to one year after the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or a denial of benefits. § 725.310(a) (April 1, 2000).

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). Furthermore, the Sixth Circuit Court of Appeals stated that a modification request need not specify any factual error or change in conditions. *See Consolidation Coal Company v. Director, OWCP [Worrell]*, 27 F.3d 227 (6th Cir. 1994), adopting the Fourth Circuit Court of Appeals standard as set forth in *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993). "A claimant may simply allege that the ultimate fact--disability due to pneumoconiosis--was mistakenly decided, and the deputy commissioner may, if he so chooses, modify the final order on the claim. There is no need for a smoking-gun factual error, changed conditions, or startling new evidence." *Id*.

In determining whether a change in conditions has occurred requiring modification of the prior denial, the Board similarly stated that,

> [T]he Administrative Law Judge is obligated to perform an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial), considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Kingery v. Hunt Branch Coal Co., BRB No. 92-1418 BLA (Nov. 22, 1994); *See also Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993). Furthermore,

> [I]f the newly submitted evidence is sufficient to establish modification . . ., the Administrative Law Judge must consider all of the evidence of record to determine whether Claimant has established entitlement to benefits on the merits of the claim.

Kovac v. BNCR Mining Corp., 14 B.L.R. 1-156 (1990), *modified on recon.*, 16 B.L.R. 1-71 (1992).

The District Director previously determined that Claimant had failed to prove any of the elements of entitlement. Therefore, all of the evidence submitted in conjunction with this third claim will now be reviewed to determine whether there was a mistake in the determination of fact, and the newly submitted evidence will be reviewed to determine whether there has been a material change in conditions since the request for modification.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The newly submitted record does not include any x-ray evidence since Claimant's January 2006 request for modification. Therefore, Claimant has not proven a change of conditions under subsection (a)(1).

The previously submitted record includes one interpretation of one x-ray and a quality only reading. Dr. Fax determined that the August 30, 2004 film was negative for pneumoconiosis. There were no positive interpretations. Therefore, since all of the x-ray evidence in the third claim for benefits is negative, I find that Claimant has not shown a mistake in fact under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has not established the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary

> function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,*. 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

As part of the third claim, Dr. Grodner considered Claimant's smoking and coal mine employment histories, non-qualifying PFT and ABG studies, and physical examination results. He concluded that Claimant did not suffer from pneumoconiosis, and that the COPD was possibly related to smoking. While this conclusion is arguably equivocal, since Dr. Grodner's report was the only pre-modification medical report submitted in conjunction with the third claim, and since the burden is on the Claimant to prove each element of entitlement, I find that there was no mistake in fact in the Director's determination that Claimant does not suffer from pneumoconiosis under subsection (a)(4).

Dr. Sicioiano's CT scan report was included as evidence under Claimant's request for modification. Dr. Sicioiano did not diagnose pneumoconiosis based on these slides. At present, "[t]he clinical diagnosis and follow up of pneumoconiosis in most workforces at risk for pneumoconiosis are still based on the changes in the lung visible by standard X-ray techniques." *Consolidation Coal Co. v. Director, OWCP*, 294 F.3d, 885, 892 (7th Cir. 2002)(quoting Q.T. Pham, *Chest Radiography in the Diagnosis of Pneumoconiosis*, 5(5) INT. J. TUBERC. LUNG DIS. 478 (2001)). As a result, the Department of Labor has rejected the view that a CT-scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). CT scans, however, when evaluated by qualified experts are "important diagnostic tools that have resulted in major improvements in the assessment of occupational lung disease." *Consolidation Coal* 294 F.3d 892. Such qualified experts are generally "radiologists (some of whom may in addition be classified as B readers) who have specialized knowledge and have developed a certain expertise through years of training and experience interpreting this particular test." *Id*. at 894 (citing J.F. Wiot & O. Linton, *The Radiologist and Occupational Lung Disease*, 175(2), AM. J. ROENTGEN. 311 (2000)). A pulmonologist may have the knowledge, training and experience to review a CT scan and reliably discuss whether the test discloses the presence of pneumoconiosis, but a party must qualify an individual pulmonologist as such an expert. *Id*.

Further, the results of a CT scan must be interpreted in conjunction with the occupational history, clinical examination, pulmonary function tests, x-rays, arterial blood gas tests and the reasoned opinions of all the experts and physicians. *Id*. at 892. Dr. Sicioiano's credentials are not part of the record, and neither party has attempted to qualify him as an expert. Therefore, I accord his negative diagnosis only some weight.

In August 2003, Dr. Mavi considered accurate smoking and coal mine employment histories, a non-qualifying PFT, and a physical examination to diagnose that Claimant suffered from COPD and pneumoconiosis. In addition, over the course of the next two and one half years, he examined Claimant and performed similar testing. On nine separate occasions, he diagnosed pneumoconiosis by history. "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v.Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988).

While I would typically accord Dr. Mavi's opinion as Claimant's treating physician substantial weight, in conjunction with his last treatment note, he submitted a letter stating that pneumoconiosis was "strongly considered" because extended exposure to coal dust can cause the disease. An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000); *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease). Also, a medical opinion based upon generalities, rather than specifically focusing upon the miner's condition, may be rejected. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985). Further, it is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports which were eight months apart rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in a earlier report and then, without explanation, found no total disability in a report issued five years later). *See also Brazzale v. Director, OWCP*, 803 F.2d 934 (8th Cir. 1986) (a physician's opinion may be found unreasoned given inconsistencies in the physician's testimony and other conflicting opinions of record). Not only is Dr. Mavi's medical report equivocal, but he clearly demonstrates that he based his diagnosis of pneumoconiosis on generalizations about the effects of coal dust exposure and not on Claimant's specific conditions and test results. In addition, his February 2006 medical report is clearly inconsistent with his previous, definitive diagnoses of pneumoconiosis (for which he never provided any reasoning as to how he came to a diagnosis of pneumoconiosis). Therefore, based on these deficiencies, I find that Dr. Mavi's opinion is insufficiently reasoned, and thus, accord his conclusions little weight.

Dr. Grodner's medical evidence review considered all of the newly submitted treatment records. He opined that neither the x-ray nor CT scan evidence was positive for pneumoconiosis. In addition, while he diagnosed COPD, he concluded that since the condition was obstructive and not restrictive, Claimant's condition was related to smoking. I find the objective evidence Dr. Grodner considered adequately supports his opinion. Therefore, I find that his opinion is well-reasoned and well-documented and accord it probative weight.

The newly submitted evidence includes one well-reasoned and well-documented opinion finding that Claimant does not suffer from pneumoconiosis, and one equivocal opinion concluding that he has the disease. Therefore, considering all of the newly submitted evidence of record, I find that Claimant has not proved that he suffers from pneumoconiosis under subsection (a)(4). Thus, I find that Claimant has not demonstrated a change of conditions in this element of entitlement.

Total Disability

Claimant may establish that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.304. The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Also, Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

The record does not include any evidence that Claimant suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. None of the newly submitted PFTs, or those submitted in conjunction with the third claim, produced values that meet the requirements of the tables found in Appendix B of Part 718. Therefore, considering the PFT evidence, I find that Claimant has not demonstrated a change in condition or a material mistake in fact under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. There were no newly submitted ABG studies, and the only study submitted with the third claim failed to produce values that met the requirements of the tables found in Appendix C of Part 718. Therefore, I find that Claimant has not demonstrated a change in condition or a material mistake in fact under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with

right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant was last employed in the coal mines working as a beltman where he repaired and assembled the belt lines. (DX 5; Tr. 22).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Non-respiratory and non-pulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986). In addition, an unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). Furthermore, a physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984).

As part of the third claim, Dr. Grodner considered Claimant's coal mine employment history, non-qualifying PFT and ABG studies, and physical examination results. He opined that Claimant had a mild pulmonary impairment and that he would be able to perform his previous coal mine employment from a pulmonary standpoint. I find that Dr. Grodner's opinion is adequately supported by the objective evidence he considered, and thus, I find his opinion well-reasoned and well-documented and accord it probative weight. Furthermore, since Dr. Grodner's report was the only pre-modification medical report submitted in conjunction with the third claim, I find that there was no mistake in fact in the Director's determination that Claimant is not totally disabled from a pulmonary or respiratory standpoint under subsection (b)(2)(iv).

Dr. Grodner was also the only physician to submit a report in conjunction with Claimant's request for modification that addressed the issue of total disability. Considering Claimant's treatment records, Dr. Grodner opined that Claimant had mild to moderate COPD and emphysema, which would make it difficult to perform the exertional requirements of his last coal mine employment. However, Dr. Grodner also stated that Claimant would have difficulty in performing his previous coal mine work based on his combined pulmonary condition, heart

disease, hypertension and hyperlipidemia. I do not find Dr. Grodner's "difficult to perform" conclusion to be equivalent to a finding of total disability. Furthermore, I find that Dr. Grodner has based this "difficult to perform" opinion on a combination on pulmonary and non-pulmonary conditions, and thus, he has not definitively concluded that Claimant is or is not totally disabled solely from a pulmonary perspective. [11]

After weighing all of the newly submitted medical evidence concerning total disability under §718.204(b)(2), I find that Claimant has failed to establish that he is totally disabled from a pulmonary perspective. Furthermore, even if I had determined that Dr. Grodner's conclusion constituted an opinion that Claimant was totally disabled, I would find that opinion to be equivocal based on his failure to clearly state whether the pulmonary impairment was, by itself, sufficient to prevent Claimant from performing the exertional duties of his former job. Thus, according more weight to the non-qualifying test results, I would continue to find that Claimant does not suffer from a totally disabling respiratory impairment, and thus, he cannot establish that his total disability is due to pneumoconiosis. Therefore, I find that Claimant has not proved that is he totally disabled. Thus, Claimant has failed to establish a change in condition.

As Claimant has failed to prove by a preponderance of the newly submitted medical evidence at least one element of entitlement, which defeated entitlement in the previous decision, I find that he has not established a change in condition. Furthermore, I do not find the newly submitted evidence, when considered in conjunction with the evidence before the District Director in the third claim, establishes a mistake in a determination of fact in the prior denial of benefits. Therefore, as Claimant has not demonstrated a mistake in determination of any fact in the previous denial of benefits and has not established a change in condition, Claimant's request for modification must be denied.[12]

Entitlement

The Claimant has failed to establish that a change in his condition has occurred since the prior denial of benefits. In addition, he has not shown that a mistake in a determination of fact occurred in the prior denial of benefits. Therefore, Claimant is not entitled to benefits under the Act.

[11] In Claimant's brief, he states that the cardiac catheterization was unremarkable, which proves that the problem was solely attributable to Claimant's lungs. While Claimant's argument is somewhat persuasive, since I found that Dr. Grodner did not definitively diagnose total disability from any cause, I find that the actual cause of this probable disability is irrelevant.

[12] Claimant's brief repeatedly reports the deficiencies with Dr. Grodner's reasoning and documentation as justification for the award of benefits. The burden, however, is on the Claimant to prove the elements of entitlement and not just to point out the problems with the Employer's evidence. Furthermore, Claimant's brief continuously cites evidence from his first and second claim to support his arguments of entitlement. However, unless the evidence submitted in conjunction with the third claim is sufficient on its own to prove a mistake in fact or a changed condition, the undersigned is not permitted to consider evidence from the first two claims.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the request of C.E.S. for modification of the previous denials of benefits is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).